



Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219

ColoradoPAR Program

Medical Review Department

Phone: 1-720-689-6340

Fax: 1-800-922-3508

QUESTIONNAIRE #2 PRESSURE RELIEF MATTRESS

Membe	r Name			Health First Co	lorado ID #		
Length Need	of	End Date		Height		Weight	
The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).							
2.	What is the complete diagnosis with complicating factors? Does the member currently have any pressure sores? State location Yes No and give a complete description which includes risk factors, i.e. Braden scale risk assessment score, multiple stage II on trunk or pelvis or any stage III or IV?						
3.	Is the member present ulcer treatment progra powered pressure redu pad?	tly on a pressure m that has inclu	uded the use o	f a non nating pressure	□ Pressure Re	No elief System ment Program	
4.	What past and current	equipment has	been trailed/	utilized?			
5.	Why isn't the current equipment (if any) meeting the member's needs?						
6.	What type of mattress member's past and prediction. Describe which group information.	esent skin condi	tion history?				
7.	Explain in detail the mo and change positions.	ember's ability t	to stand, ambu	late, transfer			
8.	How many hours per d	lay is this memb	oer in bed?				
	If this member has a h			ise explain.			
	Has there been any su				□ Yes □	No	
	Has member's nutrition						
12.	Supply any additional i medical necessity for		: will assist us i	n determining			
Print Pr	escriber Name						
Prescriber Signature							
Date Revised June 2023							sed June 2021

